PATIENT CONSENT AND WAIVER FORM FOR
DENTAL LICENSURE EXAMINATION

I, _____, hereby state that I am at least sixteen years of age, my general health is good and that I have agreed to act as a candidate's patient for the Dental Licensure examination on the following date(s): _____.

I understand that the following procedures may be performed:

- ☐ Class II amalgam restoration;
- ☐ Class III or IV composite restoration;
- ☐ Procedures associated with the fabrication of an upper arch denture; and
- ☐ Periodontal scaling and root planing.

I understand that as a part of the above listed procedures, a local anesthetic agent used in dental procedures *may* be administered.

I hereby agree to hold harmless the Indiana State Board of Dentistry, the Health Professions Bureau, and their agents and employees, for any injury that I may suffer as a result of my participation as a patient for the dental licensure examination.

_____

Patient's signature *Date*

_____

Printed or typed name

_____

Signature of parent or legal guardian (if the patient is less than 18 years of age) Date

_____

Printed or typed name

_____

Witness signature Date

_____

Printed or typed name

CANDIDATE # _____